

Child Death Review Committee

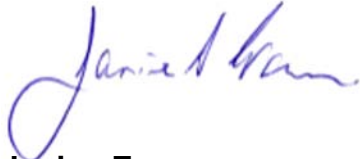
Annual Report 2018-19

Message from the Chairperson

I am pleased to submit the 2018-19 annual report for the Child Death Review Committee. This Committee is a Category 3 entity and this report was prepared under my direction and in accordance with the provisions of the **Transparency and Accountability Act**.

As per ongoing practice, consultation with officials and staff of the Department of Justice and Public Safety and other government departments occurred as necessary in relation to cases and procedures.

As Chairperson of the Child Death Review Committee, I accept accountability on behalf of the entire Committee for the content of this report and actual results reported.



Janine Evans
Chairperson

Table of Contents

Message from the Chairperson	i
Overview	1
Highlights	1
Report on Performance	1
Opportunities and Challenges Ahead	2
Financial Statements	2

Overview

The Child Death Review Committee is a multi-disciplinary committee established pursuant to the **Fatalities Investigations Act**. This Committee was formed in March 2014 and comprises seven members, who serve for a term established by the Lieutenant-Governor in Council. During fiscal year 2018-19, the Committee members were:

Ms. Janine Evans (Chairperson)
Ms. Anna Katic Duffy (Vice-Chairperson)
Dr. Simon Avis (Ex-Officio)
Ms. Michelle Chislett Lahey
Dr. Stephen Lee
Ms. Judy Voisey
Insp. Sharon Warren

Highlights

During the fiscal year, the Chairperson and Vice-Chairperson of the Child Death Review Committee met with officials of the Office of the Child and Youth Advocate to make a formal presentation to all staff about the work of the Child Death Review Committee and the manner in which both groups can coordinate for their mutual benefit, to further enhance the ability of both groups to address concerns related to child safety.

Additionally, the Chairperson is finalizing a five-year analysis of all child deaths from March 2014 onward, taking into account approximately fifteen variables, as well as all identifiers. This analysis is important for the purpose of tracking trends in child fatalities. The analysis will be released to the Minister of Justice and Public Safety upon completion.

Report on Performance

Issue: Compliance with the Fatalities Investigations Act

The Child Death Review Committee will review child deaths, monitor trends and make recommendations to the Minister on matters related to the prevention of child deaths, including the need for inquiries. The review process will involve an analysis of the facts contained in written reports and investigative material compiled by the Office of the Chief Medical Examiner and other reports identified as relevant by the Committee. The Committee will prepare a report on its findings and submit it to the Minister.

Objective: By March 31, 2019, the Child Death Review Committee will have reviewed child deaths in accordance with the **Fatalities Investigations Act**.

Indicators	Results
Meetings held as required to review child deaths referred from the Office of the Chief Medical Examiner.	The committee held eight meetings during the fiscal year.

A report on each child death review is submitted to the Minister.	By the end of the fiscal year, 21 reports were completed. Eighteen reports were submitted to the Minister. The remaining three reports are finalized and will be submitted to the Minister in Fall 2019.
Child death review records are submitted to the Office of the Chief Medical Examiner.	Twenty-one child death reviews were submitted to the Office of the Chief Medical Examiner during the fiscal year. Of the 21 reports, 15 were held over from the previous fiscal year due to the appointment of new Child Death Review Committee members. Six reports were related to cases referred from the Office of the Chief Medical Examiner in the current fiscal year.
Child deaths reviewed collectively to identify trends, risk factors and recommendations for the prevention of child deaths.	Child deaths are reviewed collectively to identify trends and risk factors on an ongoing basis. These trends inform recommendations for the prevention of child deaths. Since March 2014, 58 deaths have been fully tracked and analyzed, ready for release to the Minister.
Recommendations from collective reviews are submitted to the Minister.	The Child Death Review Committee completed a five-year analysis of all 58 child deaths reviewed between March 2014 and March 2019. This analysis is anticipated to be released to the Minister in Fall 2019.

Financial Statements

The Child Death Review Committee does not have a separate budget. Expenses are captured under Administrative Support within the Department of Justice and Public Safety Budget.